pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MORRIS-PACE ASSISTED LIVING INC**
LEGAL ENTITY

To operate **MORRIS-PACE PERSONAL CARE**
NAME OF FACILITY OR AGENCY

Located at **416 READING AVENUE, WEST READING, PA 19611**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **63**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **May 21,** **2026** until **May 21,** **2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **215900**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: June 1, 2026

[redacted]
Administrator
Morris-Pace Assisted Living, Inc.
[redacted]

RE: Morris-Pace Personal Care
License #: 215900

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on March 24, 2026 and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

May 27, 2026

[redacted]
MORRIS-PACE ASSISTED LIVING INC
[redacted]

RE: MORRIS-PACE PERSONAL CARE
416 READING AVENUE
WEST READING, PA, 19611
LICENSE/COC#: 21590

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/24/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MORRIS-PACE PERSONAL CARE* **License #**: *21590* **License Expiration**: *05/21/2026*

Address: *416 READING AVENUE, WEST READING, PA 19611*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *MORRIS-PACE ASSISTED LIVING INC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *08/07/2007* **Issued By**: *Reading Borough*

Staffing Hours

Resident Support Staff: *o* **Total Daily Staff**: *NaN* **Waking Staff**: *NaN*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Provisional* **Exit Conference Date**: *03/24/2026*

Inspection Dates and Department Representative

03/24/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *63* **Residents Served**: *58*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *39* **Are 60 Years of Age or Older**: *41*

Diagnosed with Mental Illness: *43* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

03/24/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/19/2026*

04/20/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/21/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/27/2026*

Inspections / Reviews *(continued)*

04/21/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *04/21/2026*
Reviewer: [redacted]
Follow Up Type: *Bypass Document Submission*

05/14/2026 Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *04/21/2026*
Reviewer [redacted]
Follow Up Type: *Not Required*

28f - Resident's Funds and 30-day Refund

1. Requirements

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident [redacted] was discharged from the home on [redacted]. The home did not have documentation of an itemized written account of the resident's funds, including notification of funds still owed to the home or a refund owed to the resident by the home.
Resident [redacted] was discharged from the home on [redacted] The home did not have documentation of an itemized written account of the resident's funds, including notification of funds still owed to the home or a refund owed to the resident by the home.

Plan of Correction ***Accept [redacted] - 04/21/2026)***

1. When a resident is discharged or passes away there must be an accounting of the monies showing refunds and/or monies still owed.
2. When resident [redacted] & [redacted] passed in our facility there was no accounting or refunds given or monies owe to the facility showing why.
3. Upon the discharge/death of residents ([redacted] & [redacted]) the Admin did not start the accounting process as required. I was not aware that this was to be completed, but I am aware now and moving forward I will make sure this is done timely and it is documented according to the regulations 2600.28F.
4. On 4/14/26 our transfer sheet was updated to fulfill the needed information to be compliant with the regulations. It states that if the family doesn't come and remove the residents belongings we will charge the rental fee for storage until it is completed.
5. As the Admin I will follow this updated form and within the 30 days of D/C or death if applicable the home will issue a refund as required.
6. I, as the Admin, am responsible for preventing future violations by completing our transfer sheet showing when the resident no longer lived in our facility, where they are now, if I know, and how much monies was owed by showing the accounting and/or refunds given. Once these answers are obtained the home will officially file the chart in storage for access upon DHS request.
*** Documentation has been sent to the families about refunds due to the deaths of their sibling on 4/21/26 to their last known address. I will continue to refund any monies and document in the residents record for compliance.*

Licensee's Proposed Overall Completion Date: *04/21/2026*

Implemented [redacted] - 05/14/2026)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

51 Criminal Background Check *(continued)*

Description of Violation

Staff Person A's date of hire was [redacted]. The home did not request a criminal background check until [redacted]

Plan of Correction ***Accept [redacted] - 04/17/2026)***

1. Criminal History Background Checks are essential for the safety & welfare of our residents.
2. Criminal BCK was not completed on the day of hire.
3. When staff person "A" was hired I was supposed to run the background check that day and did not until two days later. I believed that I had 30 days to run this however I was wrong after further review of RCG regarding regulation 2600.51.
4. Beginning 4/1/26 all new hires will be reviewed within 24 hours by Administration staff to ensure I follow this regulation. If I have not completed this task, they have the authority to run staff member background check immediately. All results will then be communicated to ensure any follow ups are conducted.
5. I will continue to use my list that I have created for hiring new staff, it includes all aspects for hiring and the needed documents for compliance. Also Beginning 4/1/26 this list will be reviewed quarterly to ensure this violation does not present itself again.
6. I as the Admin am responsible for preventing future violations by following my employee hiring list and requesting admin staff to audit this document, this way I'm not forgetting anything.

Licensee's Proposed Overall Completion Date: *04/13/2026*

Implemented [redacted] - 05/14/2026)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
3. Care for residents with dementia and cognitive impairments.
6. Safe management techniques.

Description of Violation

Direct Care Staff Person B, C, and D did not receive training in medication self administration; care for residents w/dementia & cognitive impair or safe management techniques during training year 2025.

Plan of Correction ***Accept [redacted] - 04/17/2026)***

1. The 12 hours of trainings are essential to equip our staff with the tools to ensure we are providing safety & welfare to our residents.
2. During the training Season of 2025, I did not complete 3 of the necessary trainings that are required for staff person B, C, & D.
3. On 3/26/26 & 3/27/26 I completed the needed trainings for the 3 staff persons that were missing what was required the previous year, along with the remaining staff so I am compliant with the regulations for the coming year. I have all of my training documents printed out , attached, and ready to be completed at there scheduled time.
4. on 4/1/26 All training were posted in staff break room with corresponding months, also training for 2027. If any staff are not available for the trainings I scheduled I will set aside time to complete their training when they are on the schedule and available. The date of completion will be documented on training sheet for DHS review.
5. At the end of each training I will double check to ensure missing staff members have scheduled a time to make up the training.

65f Training Topics (continued)

6. I as the Admin will be responsible for preventing future violations by making sure all staff are trained within our calendar year as required and also count the member for accuracy .

Licensee's Proposed Overall Completion Date: *04/12/2026*

Implemented ([redacted] - 05/14/2026)

85a - Sanitary Conditions

4. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

At approximately 9:45 a.m., in the bathroom next to room [redacted] there was brown fecal like matter on the floor mat and lower center section of the shower curtain.
Repeat Violation: [redacted]

Plan of Correction ***Accept [redacted] - 04/17/2026)***

1. The Sanitary conditions of our home is important for health & safety our residents and the standards we have in place.
2. On 3/24/26, during building walk through with DHS inspectors, the public bathroom next to F 4 was found to have brown matter in various spots. This incident was not reported to us however the bathroom was immediately cleaned by staff that day.
3. Beginning 3/26/26, all staff were instructed/educated during a staff training that each bathroom in this building must be documented for checks/cleanings at the beginning of their shift. If there is any issues they are to documented in our communication app that the issue was resolved for compliance of this regulation. Documentation of training is avaible upon DHS review.
4. Shower curtain was pulled and washed on 3/25/26 and 3 additional times by staff to remove the stains. Stains would not come out. I find out (4/16/26) after I wash the curtain with bleach that a resident uses hair dye and that is the brown matter on the curtain. The bleach removed almost all of the spots.
5. The maintenance man and cleaning staff are responsible that the building maintains sanitary conditions and preventing future violations. They must stay complaint and proactive with this regulation especially with the populations we serve.
6. I as the Admin will be periodically checking to see that this is a past problem and not a current one like I did today.

Licensee's Proposed Overall Completion Date: *04/16/2026*

Implemented [redacted] - 05/14/2026)

101j7 - Lighting/Operable Lamp

5. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

101j7 Lighting/Operable Lamp *(continued)*

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

At 2:00 p.m., Resident [redacted] did not have access to a source of light that can be turned on and off at bedside.
At 2:15 p.m., Resident [redacted] did not have access to a source of light that can be turned on and off at bedside.
At 1:31 p.m., Resident [redacted] did not have access to a source of light that can be turned on and off at bedside.

Plan of Correction ***Accept [redacted] - 04/17/2026)***

1. All bedrooms in our home must contain an operable lamp or other source of light that can be turned on at nighttime for our residents.
2. On 3/24/26 DHS inspectors found three residents room to not have an operable light near there bed. As a home we struggle to get our residents to comply due to them changing their rooms around without notifying anyone to ensure their room follows regulations.
3. On 3/27/26 the home purchased 10 LED push lights to ensure all residents rooms in building are following this regulation. Residents [redacted] & [redacted] rooms were installed (4/8/26)with these push lights to ensure they are now compliant with this regulation.
4. Lamps were replace back to their required location in the residents rooms. The push button lights have been ordered (3/27/26) to assist us with not repeating this violation. They arrived on 4/8/26.
5. Beginning 5/1/26, The maintenance man will be required to audit quarterly of all rooms to ensure each room has everything the regulations required. Any non compliance will be immediate fixed and resident informed of the need for the lamp next to the bed. Attached is our room audit for April, [redacted] wanted to complete this ASAP.
6. The maintenance man is responsible that all residents rooms have all the content requested by 2600.101 and by doing so we will prevent future noncompliance.

Licensee's Proposed Overall Completion Date: *04/14/2026*

Implemented [redacted] - 05/14/2026)

125a - Combustible Storage

6. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At approximately 9:46 a.m., in the laundry room located in H wing of the facility, there were linens lying against the left side of the hot water heater and a black plastic trash bag lying against the front of the hot water heater.
At approximately 9:50 a.m. in the utility room of the J unit, there was a cardboard box approximately 1 foot away from the hot water heater, and 2 wood shelves propped up against the left side of the hot water heater.

Repeat Violation: [redacted]

Plan of Correction ***Accept [redacted] - 04/20/2026)***

1. Preventing any/all combustion continues to be a priority for our facility to prevent any/all fires.
2. 3/24/26 during building walk through with DHS inspectors it was found that two areas of our home had items that were near the hot water heater, these items were immediately removed at the time of inspection.
3. Folded linen, blankets, pillowcases and wash clothes were hanging on the side of the shelving and there was a

125a Combustible Storage (continued)

black plastic trash bag laying on the floor up against the heaters base.
4. The black bag was removed and the items that were hanging on the side of the heater were re folded and placed directly on the shelving neatly to prevent them from coming into contact with the hot water heater.
5. 4/1/26 the maintenance man placed netting on the side of shelving to prevent any items from falling on, or for them coming into contact with our hot water. This way we will not have any issues with fires or combustion.
6. Maintenance man is responsible for preventing future violations by inspecting the netting monthly on our bathroom vent & behind the dryer check list. While he's in the dryer room it's just one other thing to look at to prevent fires.

Licensee's Proposed Overall Completion Date: *04/14/2026*

Implemented (CP - 05/14/2026)

141b1 - Annual Medical Evaluation

7. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident[redacted]s most recent medical evaluation was completed on[redacted]
Resident[redacted] most recent medical evaluation was completed on[redacted].
The medical evaluation dated[redacted] for Resident[redacted] does not indicate if the resident's needs can be met safely at the Personal Care Home on page 5.

Repeat Violation:[redacted]

Plan of Correction ***Accept[redacted] - 04/17/2026)***

1. All residents of our home are required to have a medical evaluation at least annually. This is to ensure our home are properly meeting the needs of each resident under our care
2. On 3/24/26 it was found that residents[redacted] were out of compliance of having an annual DME completed by PCP on time . Resident 6 DME on file was in compliance for annual completion however the area that the home can not complete (PCP signature page) was not completed for needs to be met at PCH.
3. We have been having a heck of a time getting the PCP to complete our DME due to the date of the residents annual visit. The PCP refuses to complete the DME if it's not at the time of the annual visit, they have said they do not get paid when it's done before or after their annual visit. This is a major problem when our dates don't line up with theirs. I have sent several faxes to this PCP and did not receive any response. I also sent a fax (4/2/26) to the Exec. Dir. for assistance and have not gotten a response either. This dilemma keeps creating violations for our facility and that is not due to our not making every effort to be compliant.
3. Residents[redacted] and[redacted] updated DME was obtained on 3/26/26 & 4/9/26. Resident[redacted]DME was Faxed back to pcp for completion, (4/15/26) it was returned completed.
4. I have sent several faxes to this PCP and did not receive any response due to our dates not lining up with the residents annual visit. I also sent a fax (4/2/26) to the Exec. Dir. for assistance and have not gotten a response either. This dilemma keeps creating violations for our facility and that is not due to our not making every effort to be compliant.
5. We will continue to send the residents DME to the PCP two to three months in advance of the expiration date

141b1 Annual Medical Evaluation (continued)

trying to have them completed timely and in compliance.
6. I, as the Admin am responsible for preventing this violation and I will continue to fight for the completion of the DME's on time. I will continue to reach out to the Exec. Dir's of these PCP's for assistance. I tried to call however all I get is the run around by the AI assistant.

Licensee's Proposed Overall Completion Date: *04/14/2026*

Implemented [redacted] - 05/14/2026)

187a - Medication Record

8. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.

Description of Violation

Resident [redacted] has a straight order for [redacted] by mouth daily but the Medication Administration Record documents it as15MG by mouth daily.

Plan of Correction ***Accept [redacted] 04/17/2026)***

1. Medication records must accurately reflect physician orders to ensure safe and proper medication administration.
2. The planners that we received weekly had the wrong dosage on the label inside of the planner for the Olanzapine
3. It was identified (3/24/26) by Inspector that Resident [redacted] medication dose was incorrectly documented on the planner that the Pharmacy delivered.
4. The Planner was corrected immediately after the Admin called (3/24/26)to confirm the actual dosage of the medication to reflect the accurate physician order. A new sheet was sent to meet the regulation and match the MAR.
4. On 4/1/26, a full audit of all MARs and physician orders was completed to ensure accuracy across all residents.
5. The Admin completes [redacted] audit of the Med cart on Monday's, reordering and examining the new planners for (no refills or other issue with the newly delivered planners), effective 4/1/26, the home has implemented a second weekly medication audit process. MARs and planners are reviewed each week again, with responsibility shared among all medication technicians to ensure orders are accurately transcribed and matched at all times.
6. All new medication orders will be verified weekly against the MAR at the time of transcription to prevent discrepancies by the Pharmacy, this way weekly audits are just double check for compliance. The administrator is responsible for completing this process and ensuring ongoing compliance with medication record requirements.

Licensee's Proposed Overall Completion Date: *04/14/2026*

Implemented [redacted] - 05/14/2026)

187b - Date/Time of Medication Admin.

9. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident [redacted] is prescribed Albuterol inhaler, two puffs into lungs every 4 hours. The inhaler was not available to be

187b - Date/Time of Medication Admin. (continued)

administered from [redacted] to [redacted] From [redacted] to [redacted] staff initialed the medication as administered for all doses except 11:00 a.m.

Plan of Correction ***Accept ([redacted] - 04/17/2026)***

1. Medications must only be documented as administered when they are actually given.
2. It was identified that medication was documented as administered when it was not available.
3. Staff were immediately re-educated on (3/26/26) proper documentation requirements. Especially Staff that were instructed to document omissions appropriately and notify administration by documenting correctly at the time of administration.
4. Med Cart audits by the Admin of 5 residents planners is completed on Monday's, also every (starting 4/1/26) Thursday Admin staff will pull 3 MARs to identify discrepancies. any discrepancies will be immediately fixed and documentation will be kept for review by DHS.
5. The Medication cart checks I complete weekly as sthe admin will be continued to be performed to ensure availability of medications, also the Admin/Med Staff are also completing audits of the planners on Thursdays as a back up for compliance.
6. The administrator is responsible for ensuring accurate medication documentation. Training was completed 3/26/26 about documenting properly and timely. This will assist with preventing inaccurate documentation.

Licensee's Proposed Overall Completion Date: *04/14/2026*

Implemented [redacted] - 05/14/2026)

187d - Follow Prescriber's Orders

10. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted] two puffs into lungs every 4 hours. The inhaler was not available in the medication cart and not administered as prescribed from [redacted] to [redacted].

Plan of Correction ***Accept [redacted] - 04/20/2026)***

1. Medications must only be documented as administered when they are actually given.
2. It was identified that medication was documented as administered when it was not available.
3. Staff were immediately re-educated on (3/26/26) proper documentation requirements. Especially Staff that were instructed to document omissions appropriately and notify administration by documenting correctly at the time of administration.
4. Med Cart audits by the Admin of 5 residents planners is completed on Monday's, also every (starting 4/1/26) Thursday Admin staff will pull 3 MARs to identify discrepancies. any discrepancies will be immediately fixed and documentation will be kept for review by DHS.
5. The Medication cart checks I complete weekly as sthe admin will be continued to be performed to ensure availability of medications, also the Admin/Med Staff are also completing audits of the planners on Thursdays as a back up for compliance.
6. The administrator is responsible for ensuring accurate medication documentation. Training was completed 3/26/26 about documenting properly and timely. This will assist with preventing inaccurate documentation.

Licensee's Proposed Overall Completion Date: *04/14/2026*

187d Follow Prescriber's Orders *(continued)*

Implemented (- 05/14/2026)